SCHWARZBEIN
INSTITUTE

Interim Questionnaire

Name _____ **Date** _____ **MR#**_____

Circle one: Are you feeling Better Worse or the Same as you did at your previous appointment? Comments: _____
_____
_____

Besides the results of your lab tests and studies, are there any other issues you wish to discuss today? _____
_____
_____

What hormones/medication(s) are you currently taking? Please (*) any that are new.

Drug Name	Dosage	Frequency	Drug Name	Dosage	Frequency
_____			_____		
_____			_____		
_____			_____		

What hormones/medication(s), if any, have you recently discontinued?

Drug Name	Drug Name
_____	_____

What supplements are you currently taking?

_____	_____
_____	_____
_____	_____

Has there been any new medical diagnosis or treatment, medical or surgical, that you have been given or undergone? Yes No If yes, please explain _____
_____
_____

When was your last physical exam? Date _____

MEN ONLY

Date of last prostate exam? _____ Last PSA test? _____

WOMEN ONLY

Are you current with your mammogram? Yes No Date of last exam _____

Are you current with your pap smear? Yes No Date of last exam _____

When was your last uterine ultrasound? _____ Not applicable _____

When was your last bone mineral density study? _____ Not applicable _____

Name _____ **Date** _____ **MR#**_____

STRESS

On a 10 scale (10 highest), what is your typical daily stress level? _____

Which of the following best describes your current stress(es)? Family Financial Work-Related Personal Illness Travel Other _____

I am getting at least 8 hours of uninterrupted sleep. Yes No

If no, please describe your sleep pattern _____

NUTRITION

How many meals do you eat each day? _____ How many snacks? _____

Are you following the balanced nutrition plan as prescribed? Yes No Mostly

If no or mostly, are you: Eating "fast"/processed foods Eating too many sugary foods

Skipping meals Eating too many carbohydrates Eating too few carbohydrates

Skipping snacks Not eating enough vegetables Eating too much fruit

Eating damaged fats Not eating enough protein Eating too much protein

Eating too many man-made carbohydrates Eating too many high saturated fatty foods

Not eating enough healthy fats Not getting enough variety/rotating protein sources

Circle the foods you have been advised to avoid? Gluten Cow Dairy Soy Other

Are you completely avoiding: Gluten: Yes No Cow Dairy: Yes No Soy: Yes No

Are you practicing good meal hygiene? Sitting down in a relaxed setting and taking the time to eat slowly, chewing each bite thoroughly before swallowing? Yes No

SUGAR/CHEMICALS/STIMULANTS

Are you ingesting any of the following? If yes, please quantify. (For example – coffee 3/day)

Coffee _____ Decaf Coffee_____ Tea _____ Iced Tea _____

Soda _____ Diet Soda _____ Milk _____ Fruit Juice _____

Artificial Sugars _____ Desserts_____ Preservatives _____

Alcohol _____ Tobacco/nicotine in any form _____

EXERCISE

Are you cleared for exercise? Yes No

If yes, are you getting enough exercise? Yes No

What are you doing? _____

If not exercising enough, why not? _____